# TRAINING PRIMARY PHYSICIANS: A FAMILY-PRACTICE PERSPECTIVE*

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WHO is a primary physician? Definitions abound, but most include these five elements:[1]

1) A primary doctor-patient relation

2) A commitment to continuous and comprehensive care

3) Responsibility as the patient's advocate in the medical care system, coordinating consultation, and the use of community resources

4) Acceptance of the patient as a person, whether the patient be healthy, worried, or ill; whether his disease be physical, emotional, social or spiritual; whether it be easy to classify or not

5) Accessibility as the point of entry into the system of medical care

It is often said that there are too few physicians functioning effectively as primary physicians. One reason frequently given is that too large a population of physicians are in subspecialty disciplines such as surgery which provide little primary care. Another commonly cited reason is that traditional training programs in internal medicine do not encourage the knowledge, attitudes, and skills which make primary medical practice feasible and attractive.

Dr. Robert G. Petersdorf notes:[2]

> Training programs in internal medicine probably do not provide appropriate training for primary care for the following reasons: there is probably excessive emphasis on inpatient critical-care medicine as opposed to chronic ambulatory medicine; training programs often provide the emphasis on subspecialty medicine at the expense of integrated general medicine; ambulatory disciplines such as dermatology and allergy, or peripheral disciplines such as neurology, are often given short shrift...and most residents do not have adequate

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opportunity to follow patients on a long-term basis, in pleasant surroundings and with the type of support that is seen in private practice or for that matter in most family medicine centers.

Physicians in family practice agree that the technical basis of the training of primary physicians should be broadened. However, we also place great stress on the nontechnical elements of the role of the primary physician included in the introductory definition.[3,4]

These skills and attitudes are not unique to primary care, of course, but they are essential for the primary physician. Much of the educational philosophy of family practice rests on the premise that these humanistic skills and attitudes develop more consistently and to a higher degree when the educational setting specifically and consistently elicits them. In this context our most important educational tool is the model family-practice unit. Again, its principles are not unique to family practice, but our experience with it now is substantial. Because many people are not acquainted with it, I shall devote the major portion of this discussion to the model family-practice unit and its role in fostering the attitudes and interpersonal skills of primary physicians.

There are several variations on the theme of model unit, each with its strengths and weaknesses. I shall describe the family practice unit at Overlook Hospital, as I am most familiar with it.

Overlook Hospital is a 546-bed community hospital in Summit, N.J. There are 18 residents in family practice, as well as accredited residencies in pediatrics, internal medicine, radiology, and pathology. The hospital is affiliated with the Columbia University College of Physicians and Surgeons.

Family-practice training lasts 36 months, of which a minimum of five months are devoted to pediatrics and a minimum of 12 months to internal medicine. The good working relation between family practice and internal medicine is notable. Family-practice residents function well on internal-medicine teaching teams. Often second and third-year family-practice residents supervise first-year internal medicine residents. The director of internal medicine education at Overlook Hospital teaches one session a week in the family-practice model unit.

Family-practice residents spend five months full-time in the model unit and an average of two sessions a week during other rotations. There are actually two model units, an eight-room examining suite on the hospital campus, and a three-office unit in Chatham, N.J., three miles away. The practice closely resembles a private fee-for-service group. Fees prevailing among family physicians in the community are charged. The volume of visits

has grown from 600 to 1,400 visits per month in the three years since we began with only our director's former private practice.

The model family-practice unit immerses residents in situations similar to those they will encounter when they enter practice. They experience the full range of diseases they will treat as primary physicians and, more important, they experience the emotional conflicts, frustrations, pressures, challenges, and satisfactions which make up the personal and interpersonal aspects of the function of a primary physician. Through this experience in a partly controlled and supervised setting we expect the residents to become sensitive to the personal and interpersonal elements of practice; to encounter the value system of primary care; to assess their personal emotions and behavior against these values; and, with support from the faculty, to develop those personal qualities which will enhance their effectiveness and comfort in the role of primary physicians.

For example, the resident provides comprehensive and continuous care and encounters its rewards and frustrations. The model unit's standards do not accept the alternatives of passing along a difficult patient to a consultant or circumventing the patient's perception of his problem by a technological chase for what is probably an irrelevant disease. Instead, the resident is forced to work through his problem and the patient's to make the doctor-patient relation work for both. Through endless variations of these encounters the resident learns what comprehensive, continuous care really means and how he as a physician and a person can function within this value system.

How does the model practice work? The key is an accepted fiction. We say this is our practice and these are our patients; we strive to behave by our best impulses as if we were actually in practice here (which, of course, we are). Thus, we never say clinic, but office or practice. Each resident is responsible for his patients and collectively the residents are responsible for the practice. A resident is expected to see his own patients continuously and to personally obtain coverage when he is unavoidably away. The resident's responsibility includes office visits, telephone consultation, reporting laboratory results to the patient, house calls, inpatient care, and nursing-home visits. It includes selecting consultants, maintaining relations with the family, and determining the medical plan.

Hospitalization illustrates the style of practice. When a family-practice patient needs hospitalization, his resident usually negotiates the admission through the utilization committee and the admissions department of the hospital. He does the admitting work-up and writes orders. Often, the

admission conflicts with other resident obligations. For instance, the resident may be the first-call house officer on ward pediatrics when an adult patient of his presents with chest pain. Usually, the resident turns over his urgent pediatric obligations to another family-practice resident. We always schedule two family-practice residents on each inpatient rotation for this reason. Alternatively, there is always a resident in the family-practice office who can assist in the care of the new admission until the patient's own resident is free. As he will in future practice, the resident experiences responsibility and the conflicts which occur when several responsibilities must be served at once. He cannot relinquish either pediatric ward responsibilities or the potential coronary-care unit (CCU) admission. Instead, the resident works late on what otherwise might have been a night off. He learns what is meant by continuity of care.

Subsequently, the resident visits his hospitalized patient seven days a week. Thus, while he is a house officer on the pediatrics ward he may be, in effect, an attending physician in the CCU. Should the resident wish to go away for a day or a week, he must personally arrange for another resident to visit his hospitalized patients as he would were he in practice. In essence, the responsibility to the office (or, as some would say, the clinic) has been redesigned to require the resident to function faithfully in the role of primary physician.

The faculty provides education and quality control. The full-time faculty consists of three physicians: a family physician, a pediatrician, and an internist. Several others supervise the residents part-time. A faculty physician is in each model unit during office hours. The resident consults the faculty member at the resident's initiative. In addition, with the patient's permission, the faculty member may watch the resident-patient encounter through the one-way mirror of the examining room. All notes on the progress of outpatients are read by the faculty physician. About 19% elicit written or oral feedback to the resident. Each resident also has a 15-minute sit-down appointment with the faculty during each office session and a formal in-depth evaluation every two months. The entire staff conducts a half-hour report each weekday from 7:45 to 8:15 A.M.

The faculty follows all hospitalized family-practice patients closely, but from a distance. We visit each hospitalized patient seven days a week, after the resident has visited. We enter progress notes or educational discussions on the chart, but usually not orders. If there is a problem we page the resident and discuss it. The faculty member also serves as back-up or second-call physi-

cian for the resident covering the practice, both at night and on weekends.

The model family-practice unit is a major investment in money, time, and effort. It provides an excellent breadth of patient-care experience. More important, it enables the resident to try, to experiment with and to grow into the nontechnical aspects of the primary-physician role. The strategy depends on the commitment of the faculty to high standards and on peer pressure among the residents. Success depends on the maintenance of an environment which permits and supports behavior consistent with model primary family-practice care and which discourages the opposite or indifferent behavior.

For example, a resident treating a patient with diabetes mellitus in the family-practice unit would be asked about the advantages of continuous versus intermittent insulin therapy, as he would were he a resident in internal medicine. We probably would not ask about the effect of insulin on intermediary metabolism. However, we always ask whether the patient received adequate education about ketoacidosis and urine testing. The resident also knows that if his patient develops diabetic coma, this would be presumed to represent a failure on the part of the physician, which would be criticized.

Other primary-physician activities are praised and reinforced, e.g., communicating clearly with the family, making the indicated house call, persisting with the uncommunicative consultant, coming in to make hospital rounds on a vacation day, going the extra mile to get an alcoholic patient into a rehabilitation program, maintaining perspective in the face of passive aggression, staying with the dying patient and his family, and demonstrating that he cares.

Does it work? For their level of training our family-practice residents are more sensitive, mature, and effective in their role as primary physicians than are most traditional internal-medicine residents I have observed. I still am surprised and impressed on Sundays when I see residents bringing to the office ill patients who were met at church. But will the good attitudes and behavior persist in practice after five or 15 years? We really do not know. We believe that a larger proportion of residents who serve three years in a model unit, where primary-care instincts are specifically encouraged, will perform the primary-physician functions more effectively, more consistently, and with greater satisfaction than residents trained in settings where these standards and values are prized less highly.

Finally, a word about the similarities and differences between family-practice and primary-care internal medicine. There are differences, but these are relatively minor compared to the broad fundamental areas of agreement.

In the east, where family-practice obstetrics and inpatient surgery are not emphasized, the formal curricula of family-practice and primary-care internal medicine hardly are distinguishable, except for the pediatric experience.[5] Nor is there disagreement about the importance of interpersonal skills, continuity of care, accessibility, or the personal doctor-patient relation. Indeed, several of the primary-care internal medicine programs have developed their own versions of the model-practice unit.

The much ballyhooed conflict between family-practice and primary-care internal medicine has been misinterpreted. Of course this is partly attributable to the inevitable competition between overlapping groups in an era of shrinking budgets. But, more important, I believe that the essential conflict is really not between family-practice and primary-care internal medicine, but between physicians who believe in training specifically for primary care—such as myself, Dr. Petersdorf, and others, including many prominent academicians, who are deeply ambivalent about modifying the basic premise that the best way to train any physician is exclusively through the detailed and scientific study of gravely ill individuals. This is a legitimate issue for debate. Do we really need more primary physicians? Do the primary-care programs in family practice and primary-care internal medicine offer better training than traditional residencies? These issues are sometimes obscured by the noisier debate as to who the primary physician is. It is more important to ask how we should train physicians to best fulfill the primary-physician role.

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